Section 2

CROSS-CUTTING ISSUES:
Harborview Medical Center and its Priority Populations

This section of the Priority Patient report is entitled “cross-cutting issues”. It will focus on three key issues that impact multiple populations described within the report. The three were chosen to respond most closely to the work currently underway by the Health Status and Health Systems Project. The issues cover financial access to care and the importance of the safety net delivery system and regional systems of care; the integration of both funding and delivery systems for substance abuse, mental health and medical care; and lastly the challenges faced by our newest community members, immigrants from Southeast Asia, Africa and other non-Western cultures seeking health care in the United States. Harborview Medical Center looks forward to working with the Health Status and Health Systems Project and others on these issues.

As health care policies, reduced public funding for health care and a highly competitive market shape how health care is delivered, there will be increasingly more unsponsored or marginally insured patients who will seek out care at HMC and other "safety net" providers. Regional systems of care, such as trauma and burn, which serve the entire community regardless of ability to pay will bear an unequal burden of uncompensated care. HMC's challenge, and that of other health care providers, will be to adequately care for these populations given limited finances.

Background:

As the position paper prepared for the Health Systems and Health Status Project in July 1996 points out, one of the barriers to health care is lack of insurance coverage. One in five Americans is uninsured for some period of time during the year. A recent survey in King County showed that 11.4% of County residents were uninsured at the time the survey was taken.

The major sources of support for the uninsured or underinsured have been Medicaid and a variety of programs supported by public dollars including programs for those with AIDS, STD, TB. Medicaid is by far the single largest funder of health care for low income people; however, it only covers about 58% of those with incomes below the federal poverty level and an even smaller number of those with incomes below 200% of poverty. Even persons who are eligible for Medicaid are often covered only intermittently; recipients are covered on average only 8 months of the year.

At HMC alone in 1995, 62% of all outpatients visits and 42% of inpatient discharges were for indigent patients, i.e. low income patients who were covered by Medicaid or who did not have a source of payment.

Proposed reductions in funding, discussed at the national level for Medicare and Medicaid, will affect not only the people eligible for services but the level of services that will be covered.

With the potential loss of federal dollars pursuant to federal welfare and immigration reform, valuable State programs may also be affected. Reduced health and welfare funding would put pressure on those programs solely funded by the State, such as the Medically Indigent (M.I.) Program and the Basic Health Plan. (The Basic Health Plan (BHP), a state supported health insurance program for families with income less than 200% of poverty is already experiencing financial stress. Due to its limited funding, it is currently placing applicants on a waiting list estimated at over 70,000, as of 12/96).

In FY 1995, there were over 3900 inpatient admissions to Harborview for trauma and specialized emergency care. For trauma admissions to HMC, only 40% had commercial health insurance. Changes to Medicaid, Medicare and other publicly funded programs will dramatically impact the financial underpinnings of the trauma system.

Issues:

As eligibility and benefits of public programs are examined for cutbacks, the "safety net" for many people will shrink. Increasingly more people will not have access to health care coverage (unsponsored) or have limited benefits relative to their needs (underinsured); the underinsured have co-pays which are too expensive relative to their income or have catastrophic coverage but not coverage for routine care. Cost reduction measures will result in more people left without a means of financing increasingly steeper health care charges.

Regional systems of care, such as trauma and burn, which serve the entire community regardless of ability to pay will be stressed. The cost of care for the uninsured will fall unequally on those providers and communities. Limited funding has been allocated to support the statewide trauma system and patient reimbursement is inadequate to support the comprehensive needs of triage, transportation and care for critically injured individuals. Support for both the operating and capital needs of such systems is needed for them to continue as a “public good” for the entire community.

Often those who cannot afford to pay for care are the most vulnerable populations e.g. children and families in poverty, homeless individuals, those with HIV/AIDS, and non-English speaking refugees and recent immigrants. These vulnerable populations are also HMC's priority patient population.

The financial position of caring for large numbers of Medicaid and uninsured patients makes safety net and regional trauma providers extremely vulnerable to changes in health care financing.

Proposal:

King County and the State of Washington must find a way to sustain and broaden financial access to health care for those most vulnerable populations in society. National models for regional systems of trauma and burn care must be supported. We must build upon our successful models.

Public hospitals nationally are facing critical financial issues. Although not insulated from these financial concerns, the unique model developed between King County and the University of Washington in regard to HMC is one sought by other public hospitals. It has been seen by both governing bodies and public hospital providers as a means to strengthen both the financial underpinnings and the quality of care in the nation's "safety-net" delivery system. As "safety net" providers, public hospitals are seeking such relationships as a means to continue their mission in a time of limited local funds, increased community needs and market demands.

Regional cooperation in the trauma system is also a national model. The comprehensive nature of the triage, transportation, and designation for treatment of critically ill patients is unique to the Northwest. The Emergency Department and Intensive Care Units at HMC were named as best performers in a recent University HealthSystems Consortium survey. In order to operate such a high quality system, public support must be maintained.

As the Level 1 Trauma Center for a four state region, communication and ongoing collaboration are key factors to its success. Technological changes that support increased communication and shared expertise throughout the region should be sought.. Such advances support access to critical care for all residents, regardless of their ability to pay , a community benefit to all.

Local jurisdictions and organizations concerned with the health status of vulnerable populations and the continued strength of regional systems of emergency/trauma/burn care must work together for:

- Continued funding of essential health care services currently provided by the Medicaid and Medically Indigent programs,
- Preservation and enhancement of the Basic Health Plan to serve at least the targeted enrollment of 200,000 low income individuals,
- Preservation of disproportionate share at the federal and state level which recognizes the financial burden of providing for large numbers of low income individuals,
- Funding of the regional trauma system, both its infrastructure (equipment, facilities, and technology) and operating needs, to ensure appropriate triage, transportation, and care of critically injured individuals,
- Support of safety-net models, through existing bonding and public financing options.

The administrative and reimbursement structure for mental health, medical care and substance abuse do not support integration of care for dual or multiply diagnosed patients, an increasingly larger proportion of patients seen at HMC. These structures create an inability on the part of the provider to evaluate and effectively address related problems and for the patient to receive coordinated care.

Background:

The majority of patients seen at HMC are indigent, that is having low income and without commercial health insurance (see Issue 1). A growing proportion of patients are drug involved and/or mentally ill and require medical care. Fourteen percent of all people visiting the HMC Emergency/Trauma Center (ETC) in FY95 were for psychiatric reasons. Twenty-five percent of outpatient visits to HMC in FY95 were to the Community Mental Health Center (CMHC). Of those seen at CMHC, 19% were MICA-designated (mentally ill and chemically dependent). In FY95, discharges for the mentally ill and substance dependent population comprised nearly 30% of all HMC discharges; this figure does not account for many other discharges where mental illness and alcohol and drug abuse were present but not the main diagnosis in discharge.

Issues:

Many people with substance abuse problems also have mental health problems. However, the funding streams for low income individuals, the mentally ill and the chemically dependent are separate, each administered by different entities with unique eligibility requirements and benefits. Low income or indigent patients may be eligible for medical care through Medicaid administered by the Medical Assistance Administration or the Basic Health Plan administered by the State's Health Care Authority. Funding for mental health comes from the state to the Regional Services Network (RSN) which locally is King County. The RSN's decide the parameters of the public mental health program according to state defined eligibility criteria/benefits. Drug Treatment funding comes from the State Division of Alcohol and Substance Abuse to the county; treatment eligibility is narrowly defined by the state.

The mental health system has a managed care system for its patients. In addition, over three-quarters of Medicaid enrollees in King County are now in managed care. The roles and responsibilities of the two sectors are still being worked out. As Medical Assistance plans to move the disabled, including many with chronic mental health problems into managed care, it is especially important that the roles and responsibilities be more clearly delineated.

The entities responsible for administering the three funding streams also have separate patient record systems and often have separate sites for assessment and treatment. Coordinating integrated treatment becomes a challenge beyond the capabilities of individual providers and patients. A movement that has assisted coordination is the introduction of qualified service provider agreements which allows institutions to share

confidential patient information that could lead to improved care, but confidentiality requirements make it difficult to share information among the three systems.

In addition to the separate administration with eligibility and coverage, new regulations will further alienate the systems. For instance, as of January 1997, the SSI program will no longer cover substance users disabled by drug and alcohol use without another medical diagnosis. When enacted this could effect the 17% of patients discharged with a substance abuse diagnosis as well as a host of other patients, resulting in loss of coverage for these individuals.

Proposal:

In order to effectively address the increasing proportion of individuals with multiple diagnoses, providers such as HMC need to be able to evaluate and treat the individuals as a whole, not as compilation of unrelated systems. This will require the three systems, mental health, alcohol and substance abuse and medical care, to:

- Engage in discussions on how to better integrate funding streams and delivery systems in order to better serve the multiply diagnosed client.
- Educate and cross train providers in assessments and system protocols.
- Work toward having "no wrong door" so that wherever the patient enters, he/she will be referred to the appropriate treatment.
- Pursue pilot programs in this arena in anticipation of the State's plan to capitate the SSI population to ensure continuity of care, cost efficiencies and better health outcomes.
- Recognize the unique needs of target populations, such as adolescents and the homeless, to maximize opportunities for prevention and harm reduction.

The health care system is complex, based in western medicine, and oriented towards medical specialties. Patients with cultural, linguistic and intergenerational barriers often need a primer or a guide to help them access services and systems and receive appropriate care.

Background:

Many people arriving from countries with cultures and languages different than those predominant in the U.S. have difficulty understanding the organization of medical care and western medical practices. In addition, they have often left their home country under duress resulting in a range of psycho-socio issues they must address in the U.S.

The non-English speaking patient is a small but growing number of patients at HMC; from FY91 to FY95, inpatient visits increased 134% to the non-English speaking poor patient. HMC offers a centralized interpreter services program, the Refugee Clinic and community based services through its House Calls program. In addition, interpreters are available to Medicaid counselors in order to review eligibility and assist in completion and tracking of application forms. Harborview provides translation services in 65 languages, with 63,300 hourly encounters a year.

The Refugee Clinic at HMC has been in operation since 1982, and is central to Harborview's commitment to refugee and immigrant populations in Seattle and King County. Interpreters in the Clinic assist the patient in receiving primary care and negotiate the linguistic and cultural differences between western medicine and that of their country.

Issues:

While the Refugee Clinic is central to providing primary care, many of the issues related to the health and well-being of the non-English speaking patient go beyond the medical care system. Cultural and language barriers keep the patient from accessing the larger health and social services system.

The House Calls program has helped immeasurably in reaching out to non-English speaking people outside the health care institution and offering case management, support, advice, education, referral, and advocacy. The program, however, currently serves a small proportion of refugees and newly arrived immigrants who would benefit by such services.

Impending reductions in funding may gravely effect the cultural and linguistic barriers. As existing legal immigrants will be cut off of SSI benefits, and new immigrants are no longer eligible for Medicaid; interpretation, outreach, case management and advocacy services may be severely limited, affecting the health and well-being of these new U.S. arrivals.

Proposal:

There needs to be a better understanding of the non-financial barriers to care and their effect on the health of the non-English speaking population. Programs such as Community House Calls must work closely with the public health department and other community based providers to broaden the understanding of the diverse cultural needs of the King County population.

This could be improved by:

- Training within HMC and the community to improve providers understanding of the non-English speaking patient's health seeking behavior and health needs.
- Expanded use of Ethno-Med, an internet site for providers, to share health care information on serving culturally diverse populations within the United States.
- Integration of culturally appropriate mental health services within the medical care community to address the impacts of trauma and intergenerational conflict.
- Local preparation for the potential changes brought about by the newly enacted federal immigration law.

Conclusion:

These three issues reflect key concerns to Harborview and its priority populations as well as the broader health status of our community. Harborview Medical Center would like to applaud the work of the Health Status and Health Systems Project in bringing these issues to the forefront. HMC looks forward to working with the County and others in the community on these cross-cutting issues. It is clear that the issues are larger than any one entity can address. We must build upon our history of collaboration and unique community structures to continue to improve the health status of our diverse populations.